URGENT: PRE-OPERATIVE MEDICAL CLEARANCE

Date: [Date]

To: [Surgeon's Name]
Department: [Surgical Department/Facility Name]
Fax/Email: [Contact Information]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Scheduled Procedure: [Name of Surgery]
Surgery Date: [Date of Surgery]

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation] for medical clearance regarding the aforementioned urgent surgical procedure. After a review of the patient's medical history, physical examination, and relevant diagnostic tests, my assessment is as follows:

Medical History & Chronic Conditions:
[List relevant conditions, e.g., Hypertension, Diabetes, CAD]

Current Medications:
[List medications, noting any to be held or adjusted pre-operatively]

Clinical Findings & Test Results:
[Insert brief summary of EKG, Lab work, or Vitals]

Clearance Status:
[ ] The patient is **CLEARED** for surgery without restrictions.
[ ] The patient is **CLEARED** for surgery with the following recommendations:
[List specific instructions, e.g., "Continue Beta-Blocker morning of surgery"]

Risk Assessment:
The patient is classified as [ASA Class] with a [Low/Moderate/High] cardiac risk profile for this procedure.

Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice Name/Clinic]
[NPI Number]